Questions from Audiology and Hearing Instrument Specialist Training

General Regulatory Questions

Q1: How do you receive payment for a replacement or new hearing aid that is dispensed to a member within the same five-year period that a hearing aid was previously dispensed in?

A1: In order to provide a hearing aid to a member that has already received a hearing aid for that ear within the previous five-year period, the provider should request prior authorization for the replacement hearing aid. In order to determine if the member has previously received a hearing aid, you can contact Julie Clifford McCarthy at 617-348-5535 or Priscilla Portis at 617-348-5573.

Q2: If a member's hearing changes drastically within the same five-year period that the member had previously received a hearing aid, and the member's current hearing aid is no longer appropriate for his or her hearing loss, how can you address the member's need?

A2: In order to provide a hearing aid to a member that has already received a hearing aid within the previous five-year period, the provider should request prior authorization for the new hearing aid(s).

Q3: When billing for accessories (V5267) or major repairs (V5014), should the 40% markup be applied before or after the shipping has been calculated into the price?

A3: The 40% markup should be applied after the shipping costs have been added to the calculation. According to the DHCFP fee schedule at 114.3 CMR 23.00, the in-office fee for these services is the adjusted acquisition cost (AAC) plus 40%. The AAC is further defined as the invoice cost for the item, including shipping and handling, and excluding postal insurance charges.

Q4: Should I itemize my calculations in the remarks section of the paper claim form or in the remarks section of the 837 electronic claims transaction?

A4: It is not necessary to itemize your calculations in the remarks section of the paper claim form or in the remarks section of the 837 electronic claims transaction. The claim form examples that were provided contained the calculations in the remarks field for purposes of educational illustration.

Q5: Is there a maximum number of accessories that can be billed for one member?

A5: Although there is no maximum number of accessories that can be billed for one member, all accessories must be bundled into a single total charge, which must appear on a single claim line and be billed separately from the hearing aid base unit. The number of accessory units entered on the claim line should reflect the actual number of individual items dispensed as accessories. The total charges should be listed to reflect the total dollar value of the actual number of individual items dispensed as accessories. Please refer to Transmittal Letter AUD-14 (July 2006) or Transmittal Letter HIS-23 (July 2006) for additional information.

Q6: When are these billing changes effective?

A6: The changes documented in Audiology Bulletin 4 and Hearing Instrument Specialist Bulletin 12 are effective for claims with dates of service on or after December 1, 2007. Claims submitted on or after December 1, 2007, with dates of service before December 1, 2007, should be billed according to the billing procedures in effect before the changes.

Q7: Will Mass Rehab Commission be following your changes?

A7: Not necessarily; MRC billing is separate and distinct from MassHealth billing.

Q8: Why do these changes not affect hospitals?

A8: Hospitals are required by state law to have universal billing, which means that they are not allowed to modify their charges for MassHealth patients only. Hospitals that dispense hearing aids for MassHealth will continue to submit invoices, as they do today.

Q9: Why should providers calculate the 15% markup into the fee for certain services?

A9: The 15% markup exists to compensate providers that provide services in any other setting where the provider travels from his or her usual place of business to provide the service. Out-of-office rates will be 115% of their respective in-office counterparts for certain services only. See the following citations for more information:

- for dispensing fees, see 114.3 CMR 23.03(2)(a)(2);
- for earmolds, see 114.3 CMR 23.03(2)(b);
- for ear Impressions, see 114.3 CMR 23.03(2)(c);
- for batteries, see 114.3 CMR 23.03(2)(d);
- for minor repairs, see 114.3 CMR 23.03(2)(f); and
- for major repairs, see 114.3 CMR 23.03(2)(g).

Q10: Is the loss and damage deductible that the manufacturers are now charging billable to MassHealth or to the member?

A10: No, this fee cannot be billed to either the member or MassHealth. The provider should contact the manufacturer or their local representative and ask to have the fee waived for MassHealth members. Although each manufacturer charging this fee will have to be contacted on an individual basis for a waiver, many manufacturers are agreeing to such a waiver. If in need of assistance in coordinating this waiver with the manufacturer, please contact Julie Clifford McCarthy at julie.clifford-McCcarthy@state.ma.us.

Q11: Could a provider bill for an extended warranty for children using procedure code V5267?

A11: No. V5267 is an accessories code, not a warranty code. MassHealth does not cover an extended warranty. Instead, MassHealth allows replacement hearing aids within the five-year period with prior authorization.

Q12: If only one unit of a two-unit repair is billed along with charges for two units, will my claim be denied?

A12: Initially, your claim will not be denied. Your claim is paid according to the charge listed and does not consider the units billed initially. When audited and the invoice is compared to the claim form, the claim will most likely be voided and the monies recouped due to the discrepancy. Make sure to be diligent in listing the units to reflect the charges that are being billed. If you mistakenly bill for one unit, please adjust your claims, even though no change in payment would be expected. This will correct your claims records in accordance with the documentation you maintain in the member's medical records.

Q13: Does MassHealth pay for FM systems for use by a child at home?

A13: Under federal EPSDT guidelines, a provider may request prior authorization for any service that is believed to be medically necessary for an eligible child under age 21.

Q14: According to MassHealth regulations, any monaural hearing aid whose AAC (not including shipping) exceeds $500 or binaural hearing aid whose AAC (not including shipping) exceeds $1000 requires prior authorization. If the cost of the hearing aid is exactly $500 or $1000, respectively, and it is the cost of shipping that increases the total cost to greater than $500 or $1000, respectively, it is still necessary to obtain prior authorization?

A14: No. The MassHealth claims processing system has been designed with logic that allows for shipping costs above the $500/$1000 limits.

Q15: Will MassHealth accept the GY (Not a covered service) modifier at some point?

A15: No, MassHealth does not accept the GY modifier, nor does it have any plans to do so. MassHealth recognizes that these V-codes are not covered by Medicare and does not edit against them for other insurance. As such, the provider does not need to bill traditional Medicare for these V-code services, nor do they need to list a GY modifier on the claim form when billing MassHealth for these V-code services. For those non-traditional Medicare plans that do provide a partial hearing aid benefit, the provider must bill the Medicare plan first for that benefit, then bill MassHealth with the Medicare EOB.

Q16: Is there a difference between a billing file and a patient file in terms of where you need to keep the invoice on file for the member?

A16: The provider should determine where to store the invoice based on the provider's recordkeeping methods. The invoice must be available upon request from MassHealth.

Q17: Can service code V5011 be billed only in the first year after the fitting?

A17: V5011 is not payable in the first two years following the fitting, but it is covered beginning in year three

Q18: Is an audiogram and medical clearance required for billing?

A18: An audiogram and medical clearance are required in order to dispense a hearing aid (see 130 CMR 426.414 and 416.414). These must be kept in the member's medical record, but are not required to be submitted with a claim form when billing.

National Provider Identifier

Q19: What is the difference between the billing NPI and the servicing NPI?

A19: The billing NPI is the NPI that is associated with the pay-to-provider number of a provider. If a provider is enrolled with MassHealth as an individual, the provider's pay-to provider number will be the provider's individual seven-digit MassHealth provider number. If a provider is enrolled with MassHealth as a group practice and has a corporate tax ID, then the pay-to provider number is the group practice provider number. If the provider has a group pay-to-provider number, the servicing provider number will be the individual provider number of the provider who provided the services.

Q20: In what instances do you bill using a taxonomy code?

A20: A taxonomy code is not required if there is only one NPI and one MassHealth provider number. A taxonomy code is required on claims only if MassHealth specifically directs the provider to enter the taxonomy code.

Recipient Eligibility Verification System (REVS)

Q21: When checking REVS, should I refer to the corporate name or the site name to identify the member's primary care clinician?

A21: When checking REVS and locating the referring provider number, use the provider number that is associated with the listed site number.

Enrollment Questions

Q22: Whom can I contact to request an application?

A22: In order to request an application, providers should contact MassHealth Customer Service 1-800-841-2900 and request an application or log onto their customer service web account and complete the online request for an enrollment application. To obtain a customer service web account, visit www.mass.gov/masshealth and in the Online Services box, click on "Order Provider Publications." Select the "Set up a Customer Service Web Account" and complete the form.